Discussion

Although college programmes in Australasia have so far been accepted for accreditation purposes, closer scrutiny of the validity of the processes used is likely in future. If continuing medical education programmes are to remain the principal way to obtain points, attention must be given to ensuring that accredited continuing medical education activities can be shown to improve physicians' performance and clinical outcomes. The colleges are currently heavily dependent on such approaches for a variety of reasons which relate to cost, logistics, and acceptance by their members. At present the cost of the administration of the maintenance of professional standards programme is incorporated in the annual subscription. Fellows pay for their own continuing medical education and additionally for the practice quality review if they choose that option.

It seems likely that efforts will have to be made to develop and incorporate procedures which are more directly related to clinical performance. The practice quality review and physician assessment are examples of such approaches, although at present they are not widely used or mandated. Finally, Australasian colleges are likely to have to take responsibility for identifying underperforming doctors unless they wish to accept that this will be introduced by an external agency, as has happened in the United Kingdom.

Competing interests: None declared.

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Revalidation of doctors in Canada

W Dale Dauphinee

Editorial by Buckley

Medical Council of Canada, PB Box 8234, Station T, Ottawa, ON, Canada K1G 3H7
W Dale Dauphinee
executive director
dauphine@mcc.ca

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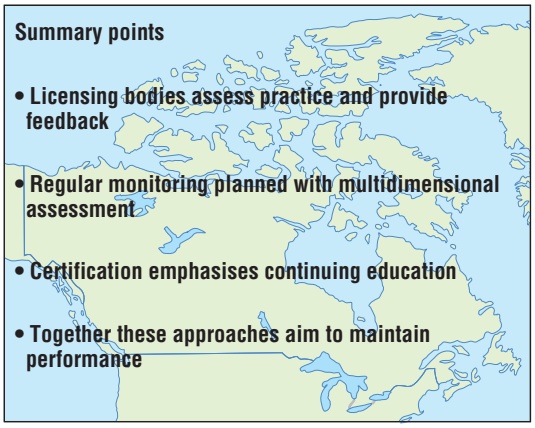
All approaches to revalidation ask doctors to prove their continuing competence to practise. This paper considers developments in Canada from two perspectives: what the profession and its regulatory bodies are doing to meet the challenge of maintaining doctors' performance, and the methods of assessment the regulatory bodies and agencies are using to address this issue. The two perspectives have led to two primary pathways: assessment related to practice activities but linked to an educational or enhancement feedback by the licensing bodies, and strategies emphasising the maintenance of good learning practices by the certifying bodies. The term revalidation is not widely used in Canada, but it can be defined as enforcing standards of practice in the medical workplace by direct measures of doctors' performance.



Methods

We reviewed the peer reviewed literature and publicly available documents describing either existing or proposed steps for the revalidation of medical licensure or certification and the maintenance of good medical learning practices in Canada. This generated a summary of the principal developments in policy and technical aspects, including a discussion of emerging challenges.

Overview of structures

Canada is a federation of 10 provinces and three territories. Health care is the responsibility of the provinces and territories. Though licensure of health professionals is a provincial matter, nationwide entry standards exist and are administered by national bodies: the Medical Council of Canada (basic medical qualifications) and the Royal College of Physicians and Surgeons of Canada (specialists) and the College of Family Physicians of Canada (family medicine). These are recognised by all jurisdictions but one.[1] National standards for the accreditation of hospitals exist, and provinces can participate in quality control through budgetary and utilisation reviews.

Role of licensure bodies

Peer review mechanisms

The medical licensing authorities have been monitoring doctors' practices for many years. For example, Canada's three most populated provinces, British Columbia, Ontario, and Quebec, have had "peer review" programmes of the records in doctors' offices since the 1980s. The Ontario experience and its five

year follow up have been described.[2 3] The licensing body, the College of Physicians and Surgeons of Ontario, carries out an office based assessment of 20 to 30 randomly selected medical records for specialists and non-specialist doctors, using explicit criteria. The practices are selected at random (but review is required of all practitioners over 70 years of age). After the selected doctor completes a questionnaire on demographic and practice profile and educational information, the review is carried out on site by a trained auditor practising in the same discipline as the doctor being assessed. If, after further interviews with peers at the college, the review indicates that a shortcoming exists, an education intervention is offered to the doctor.

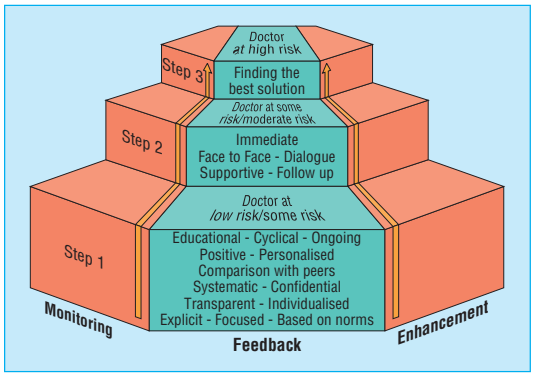
Physician assessment and enhancement programmes

Another type of assessment programme, the performance review and enhancement programme, focuses on doctors about whom there is concern (raised by self reporting, patients' complaints to the licensing authority, or as the result of peer review and inspection programmes). Page and colleagues from four provinces summarised their assessment approaches and their experience with physician review and enhancement of performance (PREP) programmes.[4] These programmes use sound principles of and practices in competency assessment and learning that results in rigorous assessment followed by focused continuing medical education that is individualised to areas of identified deficiency. Similar programmes exist in four other provinces. Follow up studies offer support for the programmes' efficiency.

Proposals for a new Canadian model

The national association of licensing authorities in Canada, the Federation of Medical Licensing Authorities of Canada, held a series of workshops in 1994-6 with input from other national medical bodies, from which emerged a new model for the maintenance and enhancement of professional performance—MEPP.[5 6] The model pursues the same principles that have directed the PREP programmes: monitor and evaluate a given doctor's performance and link it to a feedback process to "enhance" the individual doctor's performance. Three steps are proposed in the MEPP model (figure). The first two steps add to the existing PREP programmes.

In step 1 of the MEPP model, all doctors would be monitored regularly, in cycles of one to five years. The process would use practice profile data such as prescribing practices, continuing medical education credits, patient encounter data, practice profiles, and other data generated by activities like peer assessment ratings, wherein colleagues make global ratings of a colleague's performance in practice, or questionnaires administered to patients regarding their perception of the quality of care. Two of these approaches, peer assessment ratings and prescribing profiles, have been evaluated. The Quebec College of Physicians has investigated the use of the database derived from Quebec's universal drug prescription plan for the elderly to assess whether such databases could be used to assess doctors' performance. Issues such as the prescribing of drugs that represent high risk to elderly people can be monitored. It has also linked it to an enhancement process. The experience during the pilot projects has been encouraging (A Jaques, annual meeting of Federation of Licensing Authorities of Canada, Quebec, 1977).



Feedback continuum in the Canadian model for monitoring and enhancing physician performance. Two types of interventions accompany each monitoring step: offering feedback to the doctor (emphasised here) and defining a programme of enhancement, if applicable

The peer assessment ratings approach permits doctors to rate the performance of colleagues in many areas. Aspects of performance to be rated include overall clinical competence, management of psychosocial aspects of patients' illnesses, humanistic qualities, communication skills, relationships with referring doctors, technical skills, and patient management skills. The Alberta College of Physicians and Surgeons has taken particular interest in peer assessment ratings and has completed a careful study of the use of this approach with 308 doctors, finding, on the basis of pilot data with volunteer doctors, that the approach seems to be workable and delivers reliable information.[7] In another study of 255 doctors, the feedback component resulted in two thirds of the doctors undertaking changes in their practices, such as better coordination of care with other professionals or improving their written and verbal communications with others.[8]

Step 2 would involve a more careful assessment of doctors identified as at "some to moderate risk" during monitoring in step 1. Typical methods of assessment could include audits of hospital practice or procedures, office audits, and structured interviews of the doctor by trained peers. It is expected that 10-20% of doctors who seem to be at risk or "in need" in step 1 would undergo a further assessment in step 2 and that most would be found to be compliant in their practices. Only about 2% of all doctors would need to enter step 3 of the MEPP process. In many respects, step 3 is similar to the model currently functioning in Canada and focuses on the four "essential" dimensions of performance (box).

All of these assessments would be carried out under the guidance of the licensing bodies, although only the largest licensing bodies could begin to accomplish this themselves. More likely, as with the current PREP programmes, much of this could be done by assessment groups in the universities or other recognised measurement bodies. Alternatively, consortiums could be developed among assessment units in

the non-profit sector, such as the universities, research institutes, the national certifying bodies, and the Medical Council of Canada. The question remains whether the monitoring aspects of step 1 and the assessment processes of step 2 will prove as feasible (including the cost that would be funded indirectly from membership fees) and as effective as the pilot studies in Quebec and Alberta suggest. Some of these issues are under review.

Role of national certifying bodies

The certifying bodies have focused primarily on encouraging sound educational activities, and predetermined standards for these are linked to the maintenance of the doctor's certification. The programmes of the College of Family Physicians of Canada—the maintenance of proficiency (MAINPRO) programme (www.cfpc.ca/MAINPRO/calendarmainproc.htm)—and the Royal College of Physicians and Surgeons of Canada—the maintenance of competence (MOCOMP) programme (www.rcpsc.medical.org/english/public/maintofcert/mocomp_e.html)—receive high priority at both colleges. In each instance, the certificant must maintain a specified level of continuing education activities, acceptable to the specific college, or face loss of certification. Beginning in 2000, all specialists engaged in active practice and certified since 1972 must enrol in the MOCOMP programme and meet specified criteria for credits that are selected from six sets of learning options every five years. Failure to comply can lead to non-renewal of fellow status. Specialists certified before 1972 are expected to enrol, as participation is a requirement for entry on the registry of specialists.

Hospitals

Hospitals can assess the performance of doctors through processes required for formal hospital accreditation, such as tissue committees and medical acts assessment committees. Hospitals have other data on the performance of individual doctors, but there has been no pressure for public "report cards." The new maintenance of education policies at the certifying bodies and implementation of MEPP would provide hospitals with further ways of encouraging greater accountability of performance by their doctors.

Conclusion

The revalidation of doctors has moved along two pathways in Canada. In the 1980s, the direct assessment of doctors' actual practice activities began. More recently, the licensing authorities have focused on the review and formal assessment of doctors from a multidimensional assessment perspective. A three step model (MEPP) has been proposed by which licensing authorities could directly monitor all doctors (step 1) and identify those who will be investigated more carefully (step 2) before assessing a selected few in detail (step 3). To date, pilot projects have assessed two monitoring approaches: prescribing practices and peer assessment ratings. As with existing programmes in Canada, strong emphasis is to be placed on feedback to enhance performance wherever feasible and applicable.

In contrast, the certifying colleges have taken another route: formally emphasising the maintenance of good learning practices by their members. The new criteria are linked to the maintenance of the specialists' certification status, beginning in 2000. Formal recertification processes, like those used by many certification boards in the United States, have not yet been seen.

The two approaches emerging in Canada can be seen as complementary and both are anticipatory and preventive in their perspective, yet it seems that they would be able to identify and deal with an underperforming doctor. Two questions remain. If the MEPP model is formally implemented, how will members of the profession react? And in time, will the public be satisfied with these approaches or will external pressures escalate to demand other strategies?

Competing interests: None declared.

Performance: four essential areas, and associated problems[5 6]

- Use of resources: inappropriate use of resources in management of patient care
- Competence: deficient competency
- Behaviour: inappropriate behaviour
- Fitness for practice: physician impairment

Performance assessment methods in use or under development in Canada

- Drug and resource utilisation reviews
- Peer assessment ratings
- Physician review and enhancement programs
- Random office and clinic inspections
- PREP: physician review and enhancement programmes

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Endpiece

What is health?

Health is when nothing hurts very much.

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